JAN 11 2001

(8)

Supreme Court, U.S.
FILED
JAN 11 2001
OFFICE OF THE CLERK

No. 00-151

In the

Supreme Court of the United States

October Term, 2000

UNITED STATES OF AMERICA;

Petitioner,

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE, *et al.*,

Respondents.

On Writ of *Certiorari* to the
United States Court of Appeals for the Ninth Circuit

BRIEF OF FAMILY RESEARCH COUNCIL AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF *AMICUS*

Family Research Council, Inc. (hereinafter "FRC")[1] is a non-profit, research and educational organization dedicated to articulating and advancing a family-centered philosophy of public life. In addition to providing policy research and analysis for the legislative, executive, and judicial branches of the federal government, FRC seeks to inform the news media, the academic community, business leaders, and the general public about family issues that affect the nation.

FRC's legal and public policy experts are continually sought out by federal and state legislators for assistance and advice. FRC has participated in numerous *amicus curiae* briefs in the United States Supreme Court, lower federal courts, and state courts.

Lieutenant Colonel Robert L. Maginnis, USA Retired, is FRC's Vice President of National Security and Foreign Policy. He is a respected anti-drug expert having spoken at conferences in the United States and abroad. His anti-drug insights are sought by the media, grassroots activists, and government officials. In October 1999, Senator Trent Lott appointed Colonel Maginnis to the National Parents Advisory Council on Drug Abuse. Col. Maginnis has written and spoken extensively on the subject of the decriminalization of drugs and the use of marijuana for medicinal purposes. He has spoken to the following organizations on the subject of medical marijuana: Conference on why South Africa should not legalize drugs, Pratoria, South Africa, July 27-28, 2000; Illinois Police Chiefs Association, January 22, 2000; the U.S. House of

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[1] In accordance with Rule 37 of the Rules of this Court, the *amicus curiae* submit this brief in support of petitioner. All parties have consented to the submission of this brief in its entirety, and no other person or entity, besides *amicus curiae*, has made a monetary contribution to the preparation of this brief.

Representatives Subcommittee on Criminal Justice, Drug Policy, and Human Resources, "The Pros and Cons of Drug Legalization, Decriminalization and Harm Reduction," June 16, 1999; the U.S. House of Representatives Subcommittee on Crime, the Judiciary Committee, on Drug Enforcement Administration, citing FRC drug policy polling results, July 29, 1999; the Illinois Drug Education Alliance in November 1997, 1998 and 1999; the Rainbow International Association Against Drugs, San Patrignano, Rimini, Italy, October 4, 1997; Virginia House of Delegates committee concerning "medical" marijuana on January 21, 1997; conducted and published a national voter survey "America Assesses 'Medical' Marijuana" in 1997; conducted and published national voter polling on drug policy which included questions about "medical" marijuana in 1998. Col. Maginnis's writings, some of which are included herein, will be beneficial to the Court in deciding this matter.

SUMMARY OF ARGUMENT

A medical necessity exemption for marijuana is unnecessary and the harm will outweigh any benefits. The principal active ingredient in marijuana, delta-9-tetrahydrocannabinol (THC), is available in a prescribable pill called Marinol; it is also available as a rectal suppository that allows patients to absorb THC faster than Marinol or smoking crude marijuana. THC, however, is a mind-altering and dangerous substance. THC affects cognition, memory, pain perception and motor coordination. It produces euphoria and relaxation but also can deliver anxiety and panic reactions. The user's heart rate is severely elevated for up to three hours.

Crude marijuana is bad medicine that harms the brain, heart, and lungs; it limits learning, memory, perception, judgment and complex motor skills. While the evidence supports the selective use of pure THC to treat nausea associated cancer chemotherapy and to stimulate

appetite, the evidence does not support the reclassification [to Schedule II, a prescribable drug] of crude marijuana. The delivery system is unhealthful and unreliable. Marijuana smoke increases the risks for cancer, lung damage, and problems with pregnancies, including low birth weight. In addition, plants contain a variable mixture of biologically-active compounds and cannot be expected to provide a precisely defined drug effect.

Pro-marijuana arguments heavily rely on anecdotal evidence instead of controlled studies. Many people make the claim that marijuana use has helped control aspects of various diseases. Marijuana is addictive and addicts tend to feel better when they receive their drug.

Permitting "medicalization" of crude marijuana would result in many negative consequences that the federal drug laws are designed to prevent. Medicalization changes society's (particularly children's) attitudes toward the perceived dangerousness of illicit drug use. In California and Arizona, two states that have legalized marijuana for medical use, the number of current drug users of all ages was higher in California (8.3 percent) and Arizona (8.4 percent) than in the remainder of the United States (6.1 percent). Medicalization, particularly of the type practiced in California, makes marijuana much more available for illicit use. A California appeals court found that a marijuana dispensary operating in San Francisco "generally demonstrate[d] an indiscriminate and uncontrolled pattern of sale to thousands of persons among the general public, including persons who had not demonstrated any recommendation or approval of a physician and, in fact, some of whom were not under the care of a physician, such as undercover officers. Young children were seen wandering in and out of the premises, and some persons who had purchased marijuana on respondents' premises were reselling it unlawfully on the street. The declarations also reveal that respondents were importing marijuana, in violation of section 11360(a)."

There is a high correlation between marijuana use and many social and public health harms. Studies find that a high percentage of reckless drivers and accident victims used marijuana. A study testing urine samples of reckless drivers who were not obviously drunk from alcohol found that 59 percent of the drivers tested positive for cocaine and marijuana. Another study of more than 1,000 accident victims found that 35 percent had detectable levels of marijuana in their blood. In 1998, the Arrestee Drug Abuse Monitoring program found that "among juvenile arrestees, marijuana is overwhelmingly the primary drug of use." Positive rates for marijuana among male juvenile arrestees ranged from 64 percent in Phoenix to 35 percent in San Jose. In 1996, of all jail inmates, 78.2 percent had used marijuana at some point. More than half (54.9 percent) had been regular marijuana users. One-third (36.8 percent) used marijuana in the month before the offense and 18.5 percent used marijuana at the time of the offense. Marijuana is linked to 20.5 percent of cases involving child maltreatment. According to a 1990 article in the *Journal of the American Medical Association*, marijuana users caused 55 percent more industrial accidents than non-users, and had 85 percent more injuries at work than non-users.

Past periods of legalization of marijuana have produced negative consequences. Dutch tolerance of drug use has created a climate that drug manufacturers and traffickers have seized upon to produce and market more addictive and dangerous drugs. This has led to the Netherlands becoming a major producer of illicit synthetic drugs.

Medicalization of marijuana is a pretense used by many advocates of legalization. An April 1999 article in *Proceedings of the Association of American Physicians* states, "Most supporters of smoked marijuana are hostile to the use of purified chemicals from marijuana, insisting that only smoked marijuana leaves be used as 'medicine,' revealing clearly that their motivation is not scientific medicine but

the back door legalization of marijuana." In 1999, Barry McCaffrey, director of the Office of National Drug Control Policy, warned a congressional committee of "a carefully camouflaged, well-funded, tightly knit core of people whose goal is to legalize drug use in the United States."

ARGUMENT

I. A MEDICAL NECESSITY EXEMPTION FOR MARIJUANA IS UNNECESSARY AND THE HARM WILL OUTWEIGH ANY BENEFITS.

A. THC, the principal active ingredient in marijuana, is available in a refined pill form without the additional harmful effects of crude marijuana.

The principal active ingredient in marijuana, delta-9-tetrahydrocannabinol (THC), is available in a prescribable pill called Marinol®. Marinol® (dronabinol) was first approved in 1985 for the treatment of the nausea and vomiting associated with chemotherapy in patients who have failed to respond adequately to conventional antiemetic (anti-nausea) treatments. In 1992, the FDA approved a supplemental new drug application for Marinol® treatment of appetite loss or anorexia associated with weight loss in patients with AIDS.[2]

A May 1997 review of 6,059 titles in the *Annals of Internal Medicine* focused on the medical use of THC derivatives for nausea associated with chemotherapy, glaucoma, stimulation of appetite, and spinal cord spasticity. The authors state that the evidence supports the selective use of <u>pure</u> THC to treat nausea associated cancer

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[2] Marinol® (dronabinol) Drug History, Roxane Laboratories, Inc., P.O. Box 16532, Columbus, Ohio, undated.

chemotherapy and to stimulate appetite. The evidence does not support the reclassification [to Schedule II, a prescribable drug] of crude marijuana.[3]

In addition to the THC pill, researchers developed a rectal suppository that would allow patients to absorb THC faster than by Marinol or smoking crude marijuana.[4]

B. THC has its own negative side effects that prevent it from being the drug of choice for the vast majority of patients.

THC, the purified and tested form of the principal active ingredient in marijuana, is not well received because of its serious side effects. Dr. Eric A. Voth, is an assistant professor of medicine at the University of Kansas and chairman of the Institute on Global Drug Policy who has treated drug addicts for 10 years, and testified at a congressional hearing on the legalization of marijuana. Voth asserts, "The negative side-effect profile for marijuana, even dronabinol (Marinol), far exceeds most of the other effective agents available."[5] Voth backs this assertion by citing a study that ranked non-inhalant THC as only sixth in preference among oncologists for the treatment of severe nausea, and only ninth for mild nausea.[6]

THC is a mind-altering and dangerous substance. THC affects cognition, memory, pain perception and motor

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[3] Eric A. Voth, M.D. and Richard H. Schwartz, *Medicinal Applications of Delta-9-Tetrahydrocannabinol and Marijuana,* 126 Annals of Internal Med. 791 (1997).

[4] Sheila Hardwell Byrd, *Marijuana Project Develops New Treatment; Suppositories Option for Pain Management,* The Commercial Appeal, Feb. 27, 2000, at D6.

[5] *Crude Marijuana as a Medicine, Hearings on Marijuana Use in America. Before the Subcommittee on Crime of the House Judiciary Committee,* 105th Cong., 2nd Sess. 7 (statement of Eric A. Voth, M.D.).

[6] *Id.* at 6.

coordination. It produces euphoria and relaxation but also can deliver anxiety and panic reactions. The user's heart rate is severely elevated for up to three hours.[7]

The June 1997 issue of *Science* profiles two studies that demonstrate similarities between marijuana's effects (cased by THC) on the brain and those produced by highly addictive drugs such as cocaine, heroin, alcohol, and nicotine. Marijuana manipulates the brain's stress and reward systems in the same way as heroin and cocaine. One of the researchers said, "I would be satisfied if, following all this evidence, people would no longer consider THC a 'soft' drug."[8] Dr. Alan I. Leshner, director of the National Institute of Drug Abuse, commented on the study: "We know that a substantial number of chronic marijuana users become addicted, and previous research with animals has shown that stopping heavy marijuana use suddenly can cause distinct withdrawal symptoms."[9]

The psychoactive properties of marijuana may trigger latent psychopathology of many types. In some people, chronic marijuana use can produce an acute psychosis in which confusion, amnesia, delusions, hallucinations, anxiety, agitation and hypomanic symptoms predominate.[10]

The July 2000 issue of the *Journal of Immunology* states that THC can promote tumor growth by impairing the body's anti-tumor immunity system.[11]

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[7] Wayne Hall and Nadia Solowij, *Adverse Effects of Cannabis*, 352 The Lancet 1611, 1612 (1998) [hereinafter *Cannabis*].

[8] Ingrid Wickelgren, *Marijuana: Harder Than Thought?* 276 Science 1967, 1968 (1997).

[9] *Id.*

[10] Division of Neuroscience and Behavioral Health, Institute of Medicine, *Marijuana as Medicine: Assessing the Science Base* 3.29 (1999) [hereinafter *Marijuana*].

[11] Li X. Zhu, *Delta-9 Tetrahydrocannabinol Inhibits Antitumor Immunity By a cb2 Receptor-Mediated, Cytokine-Dependent Pathway*, 165 The J. of Immunology 373, 377 (2000).

In 1999, the Institute for Medicine (IOM), an independent non-profit organization released a review commissioned by the Office of National Drug Control Policy of the scientific studies of marijuana's medical worth. The review found "The effect of cannabinoids on the symptoms studied are generally modest, and in most cases, there are more effective medications."[12]

II. CRUDE MARIJUANA IS BAD MEDICINE.

The federal government classifies marijuana as Schedule I drug (21 U.S.C. § 812), meaning it is unable to be prescribed, has a high potential for abuse, is not currently accepted for medicinal use, and has a lack of safety.

Donna Shalala, Secretary of Health and Human Services, has said: "There is clear scientific evidence that marijuana is harmful to one's brain, heart, and lungs. It limits learning, memory, perception, judgment and complex motor skills like those needed to drive a vehicle. It has been shown to damage motivation and interest in one's goals and activities. It can cause chronic coughing and bronchitis. In short, it is a very dangerous drug."[13]

A. The delivery system is unhealthful and unreliable.

In the November 1996 elections, California and Arizona voters passed referenda in their states that legalized the use of marijuana as a medicine. In response, the Office of National Drug Control Policy commissioned the Institute of Medicine (IOM), an independent nonprofit organization in Washington, D.C., to review all the relevant scientific

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[12] *Marijuana, supra* note 10, at 4.

[13] *Marijuana and Tobacco Use Still Rising Among 8th and 10th Graders*, HHS News, (U.S. Dep't of Health and Human Serv., Wash., D.C.), Dec. 19, 1996.

studies of marijuana's medicinal worth. The review was not designed to address policy recommendations. In March 1999, the IOM researchers presented their findings in a book titled *Marijuana and Medicine: Assessing the Science Base*:

> Although marijuana smoke delivers THC and other cannabinoids to the body, it also delivers harmful substances, including most found in tobacco smoke. In addition, plants contain a variable mixture of biologically-active compounds and cannot be expected to provide a precisely defined drug effect. For those reasons, the report concludes that the future of cannabinoid drugs lies not in smoked marijuana, but in chemically defined drugs that act on the cannabinoid systems that are a natural component of human physiology.[14]

The 1999 IOM study concluded "[d]efined substances, such as purified cannabinoid compounds, are preferable to plant products which are of variable and uncertain composition . . . ."[15] Cannabis contains more than 400 chemicals, some of which are known to be carcinogenic.[16]

Dr. John A. Benson, Jr., one of the two researchers at IOM, and co-author of *Marijuana and Medicine* has described the medical risks of smoking marijuana:

> Marijuana's potential as medicine is seriously undermined by the fact that people smoke it, thereby increasing their chance for cancer, lung damage, and problems with pregnancies, including low birth weight. For that reason, we do not recommend smoking marijuana for long-term medical use. While we see a future in the development of

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[14] *Marijuana, supra* note 10, Preface.

[15] *Id.* at 4.

[16] Nat'l Inst. on Drug Abuse, U.S. Dep't of Health and Human Services., *Marijuana: Facts Parents Need to Know NIH Publication No. 95-4036* 5 (1995).

> chemically defined cannabinoid drugs, we see little future in smoked marijuana as a medicine.[17]

Dr. Stanley J. Watson, Jr., a researcher on medical marijuana at the IOM and co-author *Marijuana and Medicine*, has also rejected smoking marijuana for medicinal benefits:

> Although the issue of whether or not to permit patients to smoke marijuana is an important one, we believe it is really only a short-term consideration. Marijuana's future as medicine does not involve smoking. It involves exploiting the potential in cannabinoids such as THC, the key psychoactive ingredient of marijuana.[18]

A by-product of smoking crude marijuana is that it increases the patient's chances of lung cancer. One study found that marijuana smoking resulted in up to four times the respiratory burden of an equivalent amount of tobacco smoking.[19] Dr. Donald Tashkin, a lung specialist at the University of California, found that smoking marijuana damages the trachea and bronchial tubes in ways that may lead to lung cancer, and that marijuana smokers who inhale three or four joints a day suffer from chronic bronchitis as often as cigarette smokers who smoke four times as many cigarettes a day or more.[20] A September, 1993, National Institute on Drug Abuse update reported, "Daily use of one to three marijuana joints appears to produce approximately the same lung damage and potential cancer risk as smoking five times as many cigarettes."[21]

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[17] Dr. John A. Benson, Jr., Opening Statement, Press Conference Introducing *Marijuana and Medicine: Assessing the Science Base* (Mar. 17, 1999).

[18] *Id.*

[19] Tzu-Chin Wu, et al., *Pulmonary Hazards of Smoking Marijuana as Compared with Tobacco* 318 New Eng. J. of Med. 347, 349 (1988).

[20] Eric Risberg, *Blowing the Lid Off Pot*, Chicago Sun-Times, Jan. 19, 1997, at 34.

[21] *Marijuana Update*, NIDA Capsules (Nat'l Inst. on Drug Abuse, Nat'l Inst. Of Health, Rockville, Md.), Sept. 1994, at 2.

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The August 1998 issue of *The Journal of the National Cancer Institute* reported on a study that found long-term marijuana smoking might increase the risk of lung cancer. The study compared respiratory tract tissue samples from 28 healthy volunteers and 76 smokers of tobacco, marijuana and cocaine. The researchers concluded that smoking anything increased the cancer risk.[22]

Marijuana deposits four times as much tar in the lungs as does tobacco.[23] Marijuana smokers are less able to destroy fungal and bacterial organisms, as well as tumor cells.[24]

The November 1998 issue of *The Lancet*, British medical journal, included a review article titled "Adverse Effects of Cannabis." The article reveals that the typical cannabis (marijuana) cigarette is highly unpredictable in terms of THC dose delivery. Not only does it radically vary in terms of THC content, but the bioavailability of THC ranges from 5 to 24 percent.[25] The average THC content of commerical-grade marijuana is 5.57 percent, but can range as high as 25 to 30 percent, making accurate dosing nearly impossible.[26]

A November 1999 article in *The Lancet* found that inhalation of marijuana does lower eye pressure. However, the amount of marijuana smoke needed to produce clinical benefits may be associated with substantial side effects.[27]

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[22] *Smoking Drugs Linked to Cancer*, The Wash. Post, Aug. 19, 1998, at A8.

[23] *Marijuana, supra* note 10, at 3.35.

[24] *Id.* at 3.36.

[25] *Cannabis, supra* note 7.

[26] Office of Nat'l Drug Control Policy, Executive Office of the President, *National Drug Control Strategy, 2000 Annual Report* 13 (2000) [hereinafter *National*]; Gary Fields, *Potent Marijuana Strain Invigorates Drug Trade*, USA Today, Jan. 13, 1999, at 3A.

[27] Anne L. Coleman, *Glaucoma*, 354 The Lancet 1803, 1806-07 (1999).

A November 1998 review article in *Archives of Ophthalmology* concludes that smoking marijuana causes a fall in intraocular pressure (IOP) in 60 percent to 65 percent of users, but it cautions that continued use at a rate needed to control glaucomatous IOP would lead to substantial systemic toxic effects.[28]

An October 1998 study in *The New England Journal of Medicine* confirms that previous science discovered marijuana smoking can reduce IOP, but it has side effects like alterations in mental status. The authors conclude "that a deleterious effect on optic-nerve blood flow, resulting from systemic hypotension [the result of smoking marijuana] might offset any benefit of reduced intraocular pressure."[29]

A 1994 study published in *Clinical Pharmacology & Therapeutics* found that a single marijuana cigarette increased postural tracking error, decreased response speed and further impaired posture and balance. The authors concluded that marijuana smoking impairs coordination and balance in patients with spastic MS.[30]

The National Institute on Allergy and Infectious Diseases has identified two commercially available treatments for anorexia/cachexia in patients with AIDS, Megace (magastrol acetate) and Marinol. The Institute dismisses marijuana as an effective AIDS wasting drug by identifying four limitations: drug absorption via smoking may be "impractical or unacceptable;" marijuana includes "a complex mixture of over 400 compounds including

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[28] Keith Green, *Marijuana Smoking vs. Cannabinoids for Glaucoma Therapy*, 116 Archives of Ophthalmology 1433 (1998) available at http://www.ama-assn.org/sci-pubs/j...ost/recent/issues/opht/ecs8385.htm.

[29] Wallace L. M. Alward, *Medical Management of Glaucoma*, 339 The New Eng. J. of Med. 1298, 1305 (1998).

[30] Harry S. Greenberg, *Short-term Effects of Smoking Marijuana on Balance in Patients With Multiple Sclerosis and Normal Volunteers*, 55 Clinical Pharmacology & Therapeutics 324, 329 (1994).

polyaeromatic hydrocarbons which are carcinogenic;" marijuana is often contaminated with salmonella and fungal spores which compromise the immune system; and the mind altering effect may distress patients.[31]

In July 1998, *Proceedings*, the journal of the National Academy of Sciences, included an article suggesting that a chemical in marijuana may ease strokes. So far the chemical has only been tested on rats, but scientists are hopeful that the pure chemical cannabidiol will eventually be used to help stroke victims. The scientists caution that it is unlikely that anyone could get a protective dose of cannabidiol from smoking marijuana.[32]

B. The evidence supporting "medical marijuana" is largely anecdotal and the latest in depth study indicated that more research was required.

Pro-marijuana arguments heavily rely on anecdotal evidence instead of controlled studies. Many people make the claim that marijuana use has helped control aspects of various diseases. However, anecdotes are notoriously inaccurate or statistically misleading.

Robert Peterson, the director of Michigan's Office of Drug Control Policy from 1991-1995, wrote, "One must look closely at anecdotal evidence. In some of the most celebrated cases, the individual smoked pot before he or she ever got ill. Marijuana is addictive and addicts tend to feel better when they receive their drug. . . . There is no doubt that using a euphoric drug such as marijuana, alcohol,

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[31] Letter from Philip R. Lee, Assistant Secretary for Health, Dep't of Health & Human Services, to Rep. Dan Hamburg, U.S. House of Representatives, (July 13, 1994).

[32] A.J. Hampson et al., *Cannabidiol and Delta-9 tetrahydrocannabinol are neuroprotective antioxidants*, 95 Proceedings 8268, 8271 (1998).

cocaine or heroin will make a sick person feel better. That does not make a drug a medicine."[33]

The DEA petition echoes Peterson. "Sick people are not objective scientific observers, especially when it comes to their own health. We all have heard of the placebo effect. Patients have a tendency to respond to drugs as they believe is expected of them. . . Stories of marijuana's benefits from sick people with a prior history of marijuana abuse may be based on rationalizations caused by drug dependence, not on any medical benefits caused by the drug."[34]

IOM's only explicit recommendation regarding smoked marijuana was limited to strictly controlled, short-term clinical trials with the aim of separating the benefits of cannabinoids from the joint itself - a far cry from the relatively freewheeling plans of advocates of smoked marijuana and the Oakland Cannabis Buyer's Club. Although the Executive Summary of the report suggested that a small number of individuals might be given marijuana until the completion of the development of other THC delivery options, this was not one of the official recommendations made by the report, which strongly discouraged the use of smoked marijuana, citing the side effects and hazardous delivery system.[35]

The 1999 IOM paper recommended that clinical trials of smoked marijuana be conducted, but the goal "would not be to develop marijuana as a licensed drug, but rather as a first step towards the possible development of nonsmoked, rapid-onset cannabinoid delivery systems."[36] An inhaler is an example of such a delivery system. The IOM recommended that these trials, if implemented, last no longer than six months. Other qualifications on such trials

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[33] Robert E. Peterson, *Experts Agree: There Is No Medical Use for Marijuana*, Ann Arbor News, Apr. 7, 1994, at A12.

[34] Marijuana Scheduling Petition, 57 Fed. Reg. 10,499 (1992).

[35] *Marijuana, supra* note 10, at 8-9.

[36] *Id.* at 8.

include the following: documented failure of all approved medications for patients enrolled in trials; the expectation that cannabinoid drugs will relieve the specified symptom; administration of marijuana under close medical supervision; and oversight of trials by an agency similar to an institutional review board.[37]

III. PERMITTING "MEDICALIZATION" OF CRUDE MARIJUANA WOULD RESULT IN MANY NEGATIVE CONSEQUENCES THAT THE FEDERAL DRUG LAWS ARE DESIGNED TO PREVENT.

A. Medicalization of marijuana changes society's (particularly children's) attitudes toward the perceived dangerousness of illicit drug use.

Drug use among American adolescents is already high. In a government sponsored survey, *Monitoring the Future*, the University of Michigan's Institute for Social Research and the National Institute of Drug Abuse found that past-month use of marijuana is climbing. More than a fifth (21.6 percent) of all 12th graders had used marijuana in the past month, and current use among 8th graders (9.1 percent) and 10th graders (19.7 percent) continues to rise.[38]

This increase in use is a dangerous trend. An October 1999 article in the *American Journal of Public Health* found that at-risk children include those with friends using marijuana.[39] It also found the following:

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[37] *Id.* at 9.

[38] Univ. of Mich. Inst. for Social Research and the Nat'l Inst. of Drug Abuse, *Monitoring the Future* app. (2000).

[39] M. Whiteman, *The Risks for Late Adolescence of Early Adolescent Marijuana Use*, 89 Am. J. of Pub. Health 1549, 50 (1999).

"Early adolescent marijuana use is related to later adolescent problems that limit the acquisition of skills necessary for employment and heighten the risks of contracting HIV and abusing legal and illegal substances."[40]

"Future risks to adolescents who smoke marijuana include not finishing high school; delinquency; multiple sexual partners; not practicing "safe sex"; believing that drugs are not harmful; cigarette, alcohol, and/or marijuana abuse; and friends with significant deviant behavior."[41]

Studies reveal that adolescents' marijuana use is linked to their perception of its harm. As kids perceive more harm associated with marijuana, use declines.[42] A 1997 government survey of 12-to 17-year-olds in Arizona (a state that legalized "medical marijuana" at the same time as California) found considerably higher rates of current drug use than elsewhere in the country: 16.8 percent of Arizona youth were current users compared to 11.9 percent elsewhere. Nearly 12 percent of Arizona youth were current marijuana users, compared with 9.9 percent of youth in the remainder of the Untied States. The number of current drug users of all ages was higher in California (8.3 percent) and Arizona (8.4 percent) than in the remainder of the United States (6.1 percent).[43]

A 1997 Partnership for a Drug-Free America survey found that California teens are less likely than peers in other states to think that marijuana experimentation or use is risky; more likely to believe marijuana use is legal; more likely to believe that making marijuana legal as a medicine means it "isn't as harmful as I used to think"; and likely to

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[40] *Id.* at 1549.

[41] *Id.*

[42] Substance Abuse and Mental Health Services Admin., Nat'l Inst. Of Health, *Summary of Findings from the 1998 National Household Survey on Drug Abuse* 29 (1999).

[43] Substance Abuse and Mental Health Services Admin., Nat'l Inst. Of Health, *1997 National Household Survey* 3 (1997) [hereinafter *Household*].

believe that legalizing for medical purposes makes it "easier for kids my age to try marijuana."[44]

The drug-soaked Dutch have also witnessed this phenomenon. In 1984, the Netherlands essentially decriminalized cannabis. Today, there are more than 350 so-called "coffee shops" across that country where customers can legally purchase cannabis and hashish. Meanwhile, based on Dutch government adolescent drug-use surveys, teen cannabis use has skyrocketed. Between 1984 and 1996, among 12- to 18-year-olds, lifetime and current cannabis smoking rose 400 and 500 percent respectively.[45]

U.S. Attorney Jay McCloskey, Maine's top federal law enforcement official, told the *Portland Press Herald*, "[Maine's 1999 medicinal marijuana referendum] sends a very bad message to our young people, that drugs won't hurt you, that they aren't bad, that they are medicine. ... It's one more step down that road toward legalizing marijuana."[46]

"The argument about medicinal marijuana carries a greater threat to changing juvenile attitudes than any policy that's adopted," stated Mark Kleiman, a specialist in drug policy at the University of California at Los Angeles.[47]

B. Medicalization, particularly of the type practiced in California, makes marijuana much more available for illicit use.

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[44] Partnership for a Drug-Free America, *Teens' Attitudes Toward Marijuana* 4,5 (1997).

[45] S.B.M. Kuipers and W.M. de Zwart, *Trends and Patterns in Illicit Drug Use among Students Aged 12 to 18 in the Netherlands*, 29 J. of Drug Issues 549, 554, 555 (1999).

[46] Peter Pochna, *Lines Drawn on Medicinal Marijuana Use*, Portland (Maine) Press Herald, Oct. 11, 1999, at. A1.

[47] Paul Van Slambrouck, *What Teens Hear in Marijuana Debate*, The Christian Science Monitor, Mar. 22, 1999, at 1.

California allows marijuana to be grown and smoked for any illness for which it could provide relief, without age restriction. *Illness* is loosely defined, including headaches, chronic pain, and arthritis. Only a doctor's oral recommendation is required.

Marijuana contains cannabinoids which may have some moderate effect on the symptoms of certain illnesses, but that doesn't mean it should be made available in the manner recommended by the Oakland Cannabis Buyer's Cooperative. While cocaine, like Marinol, is a Schedule II drug which doctors may prescribe,[48] the government rightly assures it is distributed under very controlled circumstances, not by a "Cocaine Buyer's Cooperative." A Schedule I drug with dangerous side effects and a hazardous delivery system should be subject to stringent controls that are noticeably absent in California.

In California, there has been an emergence of "Pot Clubs" where people go to acquire and use marijuana. These clubs either bypass laws prohibiting the sale of marijuana (asking for "donations" instead), or they simply operate in direct violation of laws. These practices lead to a breakdown in drug enforcement policy and give individuals an opportunity to obtain marijuana without necessarily having the legal right to do so.

In San Francisco, "local law enforcement officials maintain a hands-off policy toward the clubs." The refusal of police to monitor individuals using these clubs leads to abuse of the law. The radical homosexual group, "Act Up," runs a dispensary on Market Street where "only those who have signed a notarized statement under penalty of perjury that they need marijuana for a medical condition and have discussed it with their doctor are eligible. They don't verify the statements, or ask for documentation."[49]

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[48] 21 U.S.C. § 812 (2000).

[49] Ulysses Torassa, *City's Pot Clubs Live On*, The San Francisco. Examiner, June 13, 1999, at D1.

On December 12, 1997, a California appeals court found:

> [The San Francisco club] generally demonstrate[d] an indiscriminate and uncontrolled pattern of sale to thousands of persons among the general public, including persons who had not demonstrated any recommendation or approval of a physician and, in fact, some of whom were not under the care of a physician, such as undercover officers. Young children were seen wandering in and out of the premises, and some persons who had purchased marijuana on respondents' premises were reselling it unlawfully on the street. The declarations also reveal that respondents were importing marijuana, in violation of section 11360(a).[50]

San Jose, Calif., allows "medical" marijuana distribution centers within 500 feet of schools, day care centers, and churches, and within 150 feet of residential areas.[51]

Enforcement officers in Arcata, Calif., faced a "law enforcement nightmare" after Proposition 215 was passed: "The city lost thousands of dollars trying to determine whether or not the smokers' claims were legitimate."[52] In order to ease problems relating to police enforcement of this type of legislation, many states are issuing identity cards showing that an individual qualifies for medicinal marijuana. These cards are coming under attack as a violation of patient-doctor confidentiality privilege and a patient's privacy of health records (and, therefore, a violation of an individual's civil liberties).

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[50] *Lungren v. Peron*, 59 Cal. App. 4th 1383 (Cal. Ct. App., Dec. 12, 1997).

[51] Maria Alicia Gaura, *San Jose Says Pot Club Has Broken Zoning Laws*, The San Francisco Chronicle, Apr. 30, 1997, at A15.

[52] Noah Isackson, *Arcata's Police Chief Hands Out 'Pot Cards' to Medical Marijuana Smokers*, Associated Press, Apr. 10, 1999, *available in* Lexis-Nexis.

Marion County, Ore., District Attorney Dale Penn said, "There have been a few individual cases here and there where an individual has attempted to use the marijuana law as an after-the-fact excuse [after being arrested for illegally possessing marijuana]."[53]

While the 1999 IOM report authors found no evidence that drug use in general would rise if marijuana were sanctioned as medicine, they qualified their statement by relying on the supposition that medical use of marijuana would be "as closely regulated as other medications with abuse potential."[54] The method of distribution permitted in California does not come close to meeting the standard the IOM authors relied on when making their statement.

C. There is a high correlation between marijuana use and many social and public health harms.

Marijuana is a dangerous drug. Marijuana is a Schedule I controlled substance (21 U.S.C. § 812), defined as having a high potential for abuse, no currently accepted medical use, and a lack of accepted safety for use. It affects memory, perception, judgment, and complex motor skills, such as those needed for driving and flying.

Marijuana is an addictive drug. In 1996, a total of 195,000 Americans entered treatment for marijuana, 62 percent of whom were under age 25.[55]

Studies find that a high percentage of reckless drivers and accident victims used marijuana. A study

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[53] Brad Cain, *New Medical Pot Law Working Smoothly*, Associated Press, Aug. 11, 1999, *available in* Lexis-Nexis.

[54] *Marijuana*, *supra* note 10, at 7.

[55] Joseph A. Califano, Jr., *Casa's Non-Medical Marijuana Report*, Address before The National Center on Addiction and Substance Abuse at Columbia University (July 1999), <http://www.casacolumbia.org/newsletter1457/newsletter_show.htm?doc_id=15629>.

testing urine samples of reckless drivers who were not obviously drunk from alcohol found that 59 percent of the drivers tested positive for cocaine and marijuana. Another study of more than 1,000 accident victims found that 35 percent had detectable levels of marijuana in their blood.[56]

In 1997, there were 64,744 marijuana-related emergency room episodes. This is a 200 percent increase since 1988.[57]

Delinquent student behavior is linked to marijuana use. Studies show that delinquent behavior such as cutting classes, stealing, attacking people, and destroying others' property increases with frequency of marijuana use.[58] A 1992 Center for Disease Control and Prevention survey found that marijuana-using adolescents drop out of school more often than non-users.[59] A 1995 study showed marijuana produces cognitive impairment.[60] A 1998 University of Maryland study found that marijuana use is highly correlated with delinquent and depressive behaviors. Among twelve to seventeen-year-olds who ran away from home, 24 percent reported weekly marijuana use; only 4 percent reported no use. Among the same age group, 26 percent of those who had physically attacked people reported weekly marijuana use, and 24 percent of those who

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[56] Alan Leshner, *New Marijuana Facts from NIDA*, The Wash. Post, Oct. 5, 1994, at A22.

[57] Office of National Drug Control Policy, Executive Office of the President, *Trends in Drug-Related Emergency Room Episodes and Selected Drug Mentions, 1988-97, in National Drug Control Strategy* 128 (1999).

[58] Office of National Drug Control Policy, Executive Office of the President, *America's Drug Use Profile, in National Drug Control Strategy* 19 (1999).

[59] *National, supra* note 26, at 125.

[60] Nadia Solowij et al., *Differential Impairments of Selective Attention due to Frequency and Duration of Cannabis Use*, 37 *Biological Psychiatry*, 731, 731 (1995).

thought about suicide smoked the drug weekly. In each case, the weekly users constituted pluralities.[61]

Adolescent users are three or more times likelier than non-users to commit theft, vandalism, driving under the influence, battery and selling of illegal drugs.[62] In 1998, the Arrestee Drug Abuse Monitoring program found that "among juvenile arrestees, marijuana is overwhelmingly the primary drug of use."[63] Positive rates for marijuana among male juvenile arrestees ranged from 64 percent in Phoenix to 35 percent in San Jose.[64]

Marijuana use is related to adult crime as well. In 1998, the percentage of all male adult arrestees testing positive for marijuana ranged from a low of 25.8 percent in Las Vegas to a high of 50.2 percent in St. Louis, Mo.[65] Other national surveys show a strong marijuana use and crime. In 1997, of all Americans aged 12 and older, 71 million (32.9 percent) had used marijuana at some point. Five percent used marijuana in the past month.[66] In comparison, in 1996,

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[61] *Practitioners Should Be Aware of Co-Occurring Marijuana Use and Delinquent/Depressive Behaviors Among Youth* CESAR Fax (Univ. of Md., College Park, Md.), Nov. 9, 1998 [hereinafter *Practitioners*].

[62] *Teen Marijuana Users Report Psychosocial Problems*, SAMHSA News (Substance Abuse and Mental Health Services. Admin., U.S. Dep't of Health and Human Services, Wash., D.C.), Summer 1998, at 2.

[63] Arrestee Drug Abuse Monitoring Program (ASAM), U.S. Dep't of Justice, *1998 Annual Report on Drug Use Among Adult and Juvenile Arrestees* 3 (1998).

[64] *Id.*

[65] In 1996, there were 28,587 (8 percent of total) drug-related felony convictions based on trials in state courts. Of that number, 12,228 were for possession. In 1996, 319,185 (92 percent of total) drug-related felony convictions were based on guilty pleas. Of that number 123,040 were for possession. Bureau of Justice Statistics, U.S. Dept. of Justice, *Felony Convictions in State Courts, in Source Book of Criminal Justice Statistics* 432 (1998).

[66] *Household, supra* note 43, at 16.

of all jail inmates, 78.2 percent had used marijuana at some point. More than half (54.9 percent) had been regular marijuana users. One-third (36.8 percent) used marijuana in the month before the offense and 18.5 percent used marijuana at the time of the offense.[67]

A 1999 survey of professionals who work in child welfare agencies or family courts found that three of four professionals cite substance abuse as one of the top three causes for the rise in child maltreatment. Marijuana is linked to 20.5 percent of these cases.[68]

According to a 1990 article in the *Journal of the American Medical Association*, marijuana users caused 55 percent more industrial accidents than non-users, and had 85 percent more injuries at work than non-users.[69]

In addition to the costs of medical care for workplace accidents, pregnancy problems, and the treatment of victims of marijuana-using criminals, marijuana contributes to national health costs through marijuana-related visits to hospital emergency rooms. Marijuana-related emergency room visits rose during the 1990s from an estimated 16,251 in 1991 to 76,870 in 1998.[70]

D. Past periods of partial legalization of marijuana have produced negative consequences.

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[67] Bureau of Justice Statistics, U.S. Dept. of Justice, *Sourcebook of Criminal Justice Statistics* 508 (1998).

[68] The Nat'l Ctr on Addiction and Substance Abuse at Columbia Univ., *No Safe Haven: Children of Substance-Abusing Parents* 14 (1999).

[69] Zwerling et al., *The Efficacy of Pre-Employment Drug Screening for Marijuana and Cocaine in Predicting Employment Outcome*, 264 JAMA 2639, 2643 (1990).

[70] *Practitioners, supra* note 61.

California lessened the penalty for possession of one ounce or less of marijuana in 1976, and, within the first six months, arrests for driving under the influence of drugs rose 46 percent for adults and 71.4 percent for juveniles.[71] In 1975, the Alaskan Supreme Court invalidated certain sections of the state's criminal code pertaining to the possession of marijuana. Based on this finding, from 1975 to 1991, possession of up to four ounces of the drug by an adult who was lawfully in the state of Alaska became legal. The court's holding did not effect the statutory provisions dealing with the purchase, sale or manufacture of marijuana, which remained illegal during this period. Even though marijuana remained illegal for children, marijuana use rates among Alaskan youth increased significantly. In response, concerned Alaskans, in particular the National Federation of Parents for Drug-Free Youth, sponsored an anti-drug referendum that was approved by the voters in 1990, once again rendering marijuana illegal.[72]

After Massachusetts passed a law permitting "medical" marijuana use, the Supreme Judicial Court ruled that the general interest in protecting the safety of employees and providing them a drug-free environment in which to work was insufficient to justify a drug-testing program.[73]

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[71] Peggy Mann, Committee of Correspondence, *Reasons to Oppose Legalizing Illegal Drugs* (1988).

[72] *The Drug Legalization Movement in America: Hearing Before the Subcomm. On Criminal Justice, Drug Policy, and Human Resources of the House Comm. On Government Reform and Oversight*, 106th Cong. (1999) [hereinafter *Hearings*] (testimony of Barry R. McCaffrey, Director, Office of National Drug Control Policy, available at http://www.house.gov/reform/cj/hearings/99.6.16/mccaffrey.htm.

[73] Jana Howard Carey, *Courts Weigh Drug Testing's Impact on Worker Privacy under State Law*, Employment Testing, Jan. 1997, at 1.

The Netherlands, one of the countries most celebrated for its loose drug laws, has also experienced negative effects from legalization for possession and small sales of marijuana. The softening of Dutch criminal laws against marijuana has led to a normalization of drug use more broadly.[74] When the so-called Dutch "coffee shops" started selling marijuana in small quantities, use of the drug more than doubled between 1984 and 1996 among eighteen to twenty five year-olds.[75] Dutch tolerance of drug use has created a climate that drug manufacturers and traffickers have seized upon to produce and market more addictive and dangerous drugs. This has led to the Netherlands becoming a major producer of illicit synthetic drugs.[76]

E. Marijuana is a "gateway" drug for many users.

The "gateway" theory is derived from the observation that most users of cocaine and heroin began their illicit drug "careers" with marijuana, tobacco cigarettes, and alcohol. Conversely, children who never use marijuana are much less likely to use harder drugs in the future than those who do smoke marijuana.

The 1999 IOM report noted that the theory that marijuana "serves as a gateway to the world of illegal drugs in which youths have greater opportunity and are under greater social pressure to try other illegal drugs . . . is supported by - although not proven by - the available data."[77]

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[74] Larry Collins, *Holland's Half-Baked Drug Experiment*, Foreign Affairs, May-June 1999, at 83-7, 88-9, 91-8.

[75] S.B.M. Kuipers and W.M. de Zwart, *Trends and Patterns in Illicit Drug Use among Students Aged 12 to 18 in the Netherlands*, 29 J. of Drug Issues 549, 554, 555 (1999).

[76] *Hearings, supra* note 72. (testimony of Barry McCaffrey).

[77] *Marijuana, supra* note 10, at 3.22.

The National Center on Addiction and Substance Abuse (CASA) is perhaps the best-known advocate of the gateway theory. In 1994, CASA published "Cigarettes, Alcohol, Marijuana: Gateways to Illicit Drug Use." That report demonstrated that adolescents who used alcohol, cigarettes and marijuana were far more likely to use drugs like cocaine than those who did not. In a subsequent publication ("Substance Abuse and the American Adolescent"), CASA researchers compared risk factors for adolescents, such as fighting and driving drunk, with the use of illicit drugs. They found that among 12- to 17-year-olds who reported no other problem behaviors, current users of cigarettes, alcohol and marijuana were almost 17 times likelier also to have used a harder drug like cocaine.[78] While CASA acknowledged that these findings were statistical rather than causal correlations, it noted:

> These relationships between use of gateway substances and other illegal drug use are more potent than early statistical relationships found between smoking and lung cancer (nine to ten times likelier in the 1964 Surgeon General's report) and between high cholesterol and heart disease (two to four times likelier in the early phases of the Framingham Heart Study).[79]

F. Medicalization is a pretense used by many advocates of legalization.

An April 1999 article in *Proceedings of the Association of American Physicians* states, "Most supporters of smoked marijuana are hostile to the use of purified chemicals from marijuana, insisting that only smoked marijuana leaves be used as 'medicine,' revealing clearly that their motivation is

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[79] The Nat'l Ctr on Addiction and Substance Abuse at Columbia Univ., *Substance Abuse and the American Adolescent* 22 (1997).

not scientific medicine but the back door legalization of marijuana."[80]

Keith Stroup, founder and executive director of NORML, announced almost 20 years ago that NORML would use the issue of "medical" marijuana to legitimize pot. He was quoted in the February 6, 1979, edition of the *Emory Wheel* (Emory University), as follows: "We are trying to get marijuana reclassified medically. If we do that ... [we will] be using the issue as a red herring to give marijuana a good name."[81]

Ethan Nadelmann, who directs the pro-drug Lindesmith Center for billionaire financier George Soros, said, "These election results send a clear message. ... It was a message for pragmatism and common sense in dealing with drugs. ... Ultimately our drug policy should be based upon one very simple notion: that people should not be discriminated against based upon the substances they consume."[82]

Officials who deal with the problem every day understand the radical agenda behind the subculture's push for "medical" marijuana.

Washington state's lieutenant governor Brad Owen worked against Initiative 692, which legalized "medical marijuana" in that state in 1998. He argued that the initiative proponents' agenda goes far beyond prescribing marijuana for sick people, saying, "The first step to legalizing drugs is to accept medical marijuana."[83]

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[80] Robert DuPont, *Examining the Debate on the Use of Medical Marijuana*, 111 Proceedings of the Ass'n of Am. Physicians 166, 166 (1999).

[81] *NORML Chairman Keith Stroup Talks on Pot Issues*, Emory Wheel, Feb. 6, 1979, at 19.

[82] Ethan Nadelmann, Keynote Address at Nat'l Organization for the Reform of Marijuana Laws Annual Conference (Nov. 12, 1998).

[83] David Schaefer, *Marijuana Initiatives Bloom Around West* The Seattle Times, Aug. 20, 1998, at B1.

In 1999, Barry McCaffrey, director of the Office of National Drug Control Policy, warned a congressional committee of "a carefully camouflaged, well-funded, tightly knit core of people whose goal is to legalize drug use in the United States."[84]

In June 1999, Drug Enforcement Administration (DEA) Deputy Administrator Donnie Marshall told a U.S. House of Representatives committee, "I suspect that medical marijuana is merely the first tactical maneuver in an overall strategy that some hope will lead to the eventual legalization of all drugs."[85]

In 1996, former presidents Bush, Carter and Ford cautioned, "Both initiatives [California's and Arizona's] are hoaxes that seek to cloak drug legalization under the guise of compassion for the ill or strengthening drug laws."[86]

CONCLUSION

For all of the above reasons, your *amicus curiae* pray that this Honorable Court will reverse the judgment of the Court of Appeals for the Ninth Circuit and reinstate the preliminary injunction entered by the U.S. District Court for Northern California against certain cannabis clubs and their agents, including Respondents, Oakland Cannabis Buyers' Cooperative and Jeffrey Jones, *et al.*

January 10, 2001

Respectfully submitted,

Janet M. LaRue

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[84] Christopher S. Wren, *Small Coalition Crusades against America's War on Drugs*, The San Diego Union-Tribune, Jan. 2, 2000, at A14.

[85] Michael Doyle, *Two Groups Roll out DEA Applications to Grow Marijuana*, The Fresno Bee, June 21, 1999, at A1.

[86] Office of Nat'l Drug Control Policy, Executive Office of the President, *Dear Fellow Citizens: An open letter from President George Bush, President Jimmy Carter, and President Gerald Ford, Oct. 29, 1996*, Medical Marijuana Information Packet.

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